

**Testimony in Support of CT S.B. No. 25
An Act Concerning Out-Of-Pocket Expenses For Prescription Drugs
Insurance and Real Estate Committee – February 24, 2014**

Chairmen Crisco and Megna, and Members of the Committee:

On behalf of The Leukemia & Lymphoma Society and the blood cancer patients we serve throughout the state of Connecticut, we thank you for the opportunity to submit written testimony on S.B. No. 25. Raised by the Insurance and Real Estate Committee, this important legislation would address cost-sharing requirements that prevent patients from accessing the medicines prescribed by their health care providers.

For many years, insurers have used tiered cost-sharing in their drug coverage as a way to encourage patients to try lower-cost medications before turning to more expensive ones. Costlier options would appear on the second or third tier of a health plan's formulary – the list of medications covered by the plan – where the patient cost-share would be a flat co-pay that increased moderately with each tier. Today, however, it is common for formularies to include a fourth, fifth, or even higher tier, where the cost-sharing is often a percentage of the cost of the medicine rather than a fixed co-pay. Known as coinsurance, this type of cost-sharing can require a patient to pay as much as 50% of a medication's cost. For example, consider a monthly course of imatinib treatment for chronic myeloid leukemia (CML). Based on the price for an average monthly supply of imatinib, a co-insurance of just 20% would require a patient to pay an out-of-pocket expense of at least \$1,200 per month. These payments are simply unaffordable for many low- and middle-income families.

These higher tiers have come to include a significant number and range of medications, including drugs that have *no* generic or lower-cost equivalent. Another emerging trend is for the highest-cost tier to contain *all* the medications available for a certain condition; for patients needing one of these treatments, even a generic option will involve a high cost-share.¹ Making this problem even worse is the growing prevalence of high deductibles in plans sold across the country. This year, in health plans sold through the state marketplaces, the average combined deductible in bronze plans is \$5,249 and, in silver plans, \$2,658.² Commonly these plans require consumers to meet their full deductible before *any* coverage is provided.³

Taken together, these benefit designs require patients to pay high upfront costs in order to access the treatment that offers the greatest potential medical benefit. This creates a serious barrier to care. It's important to note that the impact falls largely on patients facing cancer, multiple sclerosis, rheumatoid arthritis, HIV/AIDS, hemophilia, and other life-threatening diseases and chronic conditions. Health insurance is supposed to spread risk in an equitable fashion across a total insured population but, with their medications clustered on these higher tiers, these patients are saddled with a disproportionate share of their drug costs.

The adverse effects of such high cost-sharing are not limited to patient finances; these costs have also been shown to discourage adherence to treatment. In one recent study, the authors estimated that, on average, every \$10 increase in co-pay yielded a 4% decrease in adherence.⁴ Unfortunately, poor adherence can lead to poor health outcomes and to an increase in non-medication costs associated with treating disease progression and/or other complications. The New England Health Institute recently estimated that medication non-adherence results in up to \$290 billion annually in increased medical costs in the U.S.⁵

If passed, S.B. No. 25 would help address this problem by placing a cap on the out-of-pocket costs that patients can be required to cover for a 30-day supply of a single prescription medication. This cap is critical to protecting patients against the monthly financial hardship that many of them experience at the pharmacy when filling a script for just a single higher tier drug like imatinib. Also, S.B. No. 25 would ensure that these limits apply pre-deductible—meaning, the cap would be applied to a patient's out-of-pocket costs regardless of whether the plan deductible has been reached. Otherwise, when patients fill their prescriptions each month, those with higher deductibles are unlikely to experience any improvement in the affordability of their cost-share. Finally, S.B. No. 25 would prohibit a health plan from placing all prescription drugs in a given class in the highest cost-tier.

Fortunately, this bill would not have a significant impact on cost for the average commercial insurance plan. That's because the medications impacted by this cap comprise a very small percent of total health plan spending,⁶ and those costs can be effectively diluted when spread across all plan enrollees. LLS has commissioned an analysis of this and other cost-related aspects of implementing caps on cost-sharing for prescription drugs; we look forward to sharing that data with you in the coming weeks.

We thank the committee members for having raised this bill and urge your continued support for the bill's fair and balanced approach. With questions, please contact:

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¹ Jacobs, D.B. and Sommers, B.D. "Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace." *New England Journal of Medicine*. January 2015. 372: P399-P402. Available online at: <http://www.nejm.org/doi/full/10.1056/NEJMp1411376>

² Avalere PlanScape® for 2015, a proprietary analysis of exchange plan features, December 2014. Avalere analyzed data from the FPM Individual Landscape File released November 2014 and the California and New York state exchange websites.

³ Breakaway Policy Strategies and Robert Wood Johnson Foundation. "Eight Million and Counting: A Deeper Look at Premiums, Cost Sharing and Benefit Design in the New Health Insurance Marketplaces." May 2014. Available online at: <http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/05/eight-million-and-counting.html>

⁴ Eaddy et al., "How patient cost-sharing trends affect adherence and outcomes." *Pharmacy and Therapeutics*. 2012;37(1):45-55.

⁵ New England Health Institute. "Poor Medication Adherence costs \$290 billion a year." 2009. See: <http://mobihealthnews.com/3901/>

⁶ Study conducted in 2013 by Avalere Health on behalf of the Coalition for Accessible Treatments, a group of patient organizations, medical associations, and others supporting specialty tiers reforms at the federal level.